No. 300
10.48

FILED JAN 21 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 2447

BIRTH NO. _____ REG. DIST. NO. 310 PRIMARY REG. DIST. NO. 3058 Registrar's No. 46

1. PLACE OF DEATH
a. COUNTY: ST. CHARLES
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): ST. CHARLES
c. LENGTH OF STAY (In this place): 8 DAYS
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): ST. JOSEPH HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: Mo.
b. COUNTY: ST. CHARLES
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): ST. CHARLES
d. STREET ADDRESS (If rural, give location): R. F. D. # 2

3. NAME OF DECEASED (Type or Print)
a. (First): PRUSIA
b. (Middle): LEE
c. (Last): GREEN

4. DATE OF DEATH (Month) (Day) (Year): JAN 9 1957

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED, ~~NEVER MARRIED~~, ~~WIDOWED, DIVORCED~~ (Specify)
8. DATE OF BIRTH: MAY 8-1872
9. AGE (In years last birthday): 85 | IF UNDER 1 YEAR: Months 8, Days 1 | IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER
10b. KIND OF BUSINESS OR INDUSTRY: RETIRED
11. BIRTHPLACE (State or foreign country): ST. CHARLES Co. Mo.
12. CITIZEN OF WHAT COUNTRY?: USA

13a. FATHER'S NAME: JOHN GREEN
13b. MOTHER'S MAIDEN NAME: NULL
14. NAME OF ~~HUSBAND~~ OR WIFE: BEULAH GREEN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service): NO
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT'S SIGNATURE OR NAME: MRS BEULAH GREEN
ADDRESS: ST. CHARLES Mo

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Carcinoma of Pancreas — INTERVAL BETWEEN ONSET AND DEATH: 1 mo

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: None
19b. MAJOR FINDINGS OF OPERATION: 157X
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1/1, 1957, *to* 1/9, 1957, *that I last saw the deceased alive on* 1/9, 1957, *and that death occurred at* 9 A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): B. L. Neubeiser M.D.
23b. ADDRESS: 206 Washington St. Charles Mo
23c. DATE SIGNED: 1/14/57

24a. BURIAL, ~~CREMATION, REMOVAL~~ (Specify): Removal
24b. DATE: JAN. 17/57
24c. NAME OF CEMETERY OR CREMATORY: EV. + R. C. CEMETERY
24d. LOCATION (City, town, or county) (State): WELDON SPRINGS Mo

DATE REC'D BY LOCAL REG.: Jan 16 1957
REGISTRAR'S SIGNATURE: Lannie Hamilton
25. FUNERAL DIRECTOR'S SIGNATURE: E. A. Keithly
ADDRESS: O'FALLON Mo

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by .....

....., Student Embalmer No. .....,

working under my personal supervision.

Student .....
Student Embalmer

Signed E. A. Keithly

Licensed Embalmer No. 8 8 r

P. O. Address Fulton Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.